Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GRANT R MCKEEVER MD
1065 N GESSNER SUITE 300
HOUSTON TX 77055

Respondent Name
HEALTHSOUTH CORP

MFDR Tracking Number
M4-10-4686-01

Carrier's Austin Representative Box
Box Number 15

MFDR Date Received
JULY 10, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position summary was not submitted by the requesting party.

Amount in Dispute: $920.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A position summary was not submitted by the respondent.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 29, 2009	CPT Codes 99214 and 20610 HCPCS Code J3490	$920.26	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated
   - No EOBs were submitted.

Issue

1. Did the requestor submit the request for medical fee dispute resolution in the form and manner required by 28 Texas Administrative Code §133.307?

Findings

28 Texas Administrative Code §133.307(c)(2) states: "Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the

request with the Division. (2) Provider Request. The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: (A)a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills); (B)a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the requestors documentation finds that the requestor has not meet the above requirements, consequently, the amount ordered is $0.00.

Conclusion

The Division finds that the requestor has not submitted the request for medical fee dispute resolution in the form and manner prescribed by the Division for the services in dispute. For that reason, the amount ordered is $0.00.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 6, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.